BRISBANE
DAY HOSPITAL

PRE-ADMISSION FORM

Family Name		Given Names			
Date of Birth		Age		Title	
Sex	Male ☐ Female ☐ Indeterminate ☐ Transgender ☐ Transsexual ☐ Pangender ☐				
Address					
Contact Details	Mobile:	Home:		Work:	
Medicare		Health Fund			
Email Address					
Country of Birth		Language spoken			
Marital Status	Never married ☐ De Facto ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐				
Religion	Catholic ☐ Hindu ☐ Muslim ☐ Jewish ☐ Buddhist ☐ None ☐ Other ☐ _____				
Indigeneity	Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐ South Sea Island ☐ Non-Indigenous ☐				
Occupation		Impairments			
Escort Name		Escort Number			
Next of Kin		Next of Kin's Number			
Relationship to Next of Kin					
GP's Name		GP's Number			
GP Practice Name and Address					

GYNAECOLOGICAL HISTORY	
When was the first day of your last period?	
Have you taken any pregnancy tests? What were the results?	
How many children do you have?	
Have you had any Caesarean sections?	
Have you had a termination before? Medical or surgical?	
Have you ever had a miscarriage or ectopic pregnancy?	
When was your last Pap smear/CST?	
Have you ever had an abnormal Pap smear?	
When was the last time you had STI testing?	
Have you ever had any gynaecological surgery?	
Are your periods regular/irregular, light/moderate/heavy, with mild/moderate/painful cramping or no cramping?	

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MEDICAL HISTORY

Topic	No / Yes	Details
Have you or your family members ever had any problems with **anaesthetics**?	N ☐ Y ☐	
Do you have any **allergies to medications**? If yes, please provide details.	N ☐ Y ☐	
Do you have any other allergies or sensitivities?	N ☐ Y ☐	
Are you taking any **medications**? If yes, what are you taking, and how often do you take it?	N ☐ Y ☐	
Do you **smoke**? If yes, how many?	N ☐ Y ☐	
Do you use any **recreational drugs**? If yes, please specify which drug/s you use and how often you use.	N ☐ Y ☐	
Do you drink alcohol? If yes, please specify how much and how often you drink.	N ☐ Y ☐	
Are you currently breastfeeding?	N ☐ Y ☐	
Do you have any loose or broken teeth?	N ☐ Y ☐	
Do you have any respiratory conditions? (e.g. asthma)	N ☐ Y ☐	
Do you have any heart conditions? (e.g. high or low blood pressure, heart murmurs from rheumatic fever, palpitations)	N ☐ Y ☐	
Do you have any bleeding/clotting conditions?	N ☐ Y ☐	
Do you have diabetes? If yes, what type and what treatment are you on?	N ☐ Y ☐	
Do you suffer from heartburn/reflux/indigestion?	N ☐ Y ☐	
Have you had any sexually transmitted diseases?	N ☐ Y ☐	
Do you have Hepatitis A, Hepatitis B, Hepatitis C, or HIV?	N ☐ Y ☐	
Do you suffer from any psychological states? (e.g. depression, bipolar)	N ☐ Y ☐	
Do you currently have any multi-resistant infections such as MRSA, VRE, or TB?	N ☐ Y ☐	
Do you have any other medical condition(s)? If yes, please provide details.	N ☐ Y ☐	

Previous operations/surgeries	